Beth Israel Deaconess Medical Center, Boston, MA
OUTPATIENT ONLY LAB REGISTRATION
Important – Use Inpatient Form for all Inpatient Labs

(Please Print)

Medical Record Number:	Account Number:	Today's Date:

PATIENT INFORMATION

Patient's last name: First: Middle:	☐ Mr. ☐ Mrs.	☐ Miss ☐ Ms.	Marital status: Single ☐ Mar ☐ Div ☐ Sep ☐ Widow ☐		
Spouse's first name:					
Birth Date: / /	Sex/Gender: ☐ M ☐ F	Street Address:		City:	
PO Box:		Apt or Unit:		State/ Country / Zip: / /	
Social Security no: - -	Home Phone no: ( )		Work Phone: ( )		
	Other Phone: ( )				
Mother's First Name:		Father's First Name:			
Race/Ethnic Background - Please indicate:					
Primary Care Physician (PCP):		PCP Phone Number:			
PCP Address:					
Referring Physician		Referring Physician Phone Number:			
Next of Kin:		Next of Kin Phone:			
Next of Kin Address:					

EMPLOYMENT & INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Employment Status:	Full Time ☐	Part Time ☐	Not Employed ☐	Self Employed ☐	Retired ☐	Active Military ☐
Person responsible for this bill:						
Occupation:						
Employer Name and Address:						
Insurance Company Name or Plan:						
Insurance Billing Address:						
Indicate which type of plan:	HMO: ☐	PPO: ☐	PFFS: ☐	Other: ☐		
Policy Number:						
Relationship of Insured:	Subscriber ☐	Spouse ☐	Dependent ☐	Other ☐	Indicate -	
Name of Insured:						
Insurance Start Date:						
Is this Group Coverage? Yes ☐ No ☐		If Yes, Group Number:				

Additional Insurance

Insurance Company Name or Plan:						
Insurance Billing Address:						
Indicate which type of plan:	HMO: ☐	PPO: ☐	PFFS: ☐	Other: ☐		
Policy Number:						
Relationship of Insured:	Subscriber ☐	Spouse ☐	Dependent ☐	Other ☐	Indicate -	
Name of Insured:						
Insurance Start Date:						
Is this Group Coverage? Yes ☐ No ☐		If Yes, Group Number:				